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Wilmington, NC 28401
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Privacy Oficer
910-465-1935
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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

You have the right to protect your health information. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

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Your Rights continued

Ask us to limit what we use or share	You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

[redacted]

[redacted]. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	- Share information with your family, close friends, or others involved in your care - Share information in a disaster relief situation - Include your information in a hospital directory - Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	- Marketing purposes - Sale of your information - Most sharing of psychotherapy notes
In the case of fundraising:	We may contact you for fundraising efforts, but you can tell us not to contact you again.

[redacted]

We typically use or share your health information in the following ways.

Treat you	We can use your health information and share it with other professionals who are treating you.	*A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*We use health information about you to manage your treatment and services.*
Bill for your services	We can use and share your health information to bill and get payment from health plans or other entities.	*We give information about you to your health insurance plan so it will pay for your services.*

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[redacted]: We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: - Preventing disease - Helping with product recalls Reporting adverse reactions to medications Reporting suspected abuse, neglect, or domestic violence Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: For workers' compensation claims For law enforcement purposes or with a law enforcement official With health oversight agencies for activities authorized by law For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Instruction C: Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."

Instruction D: The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.

Instruction E: If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.

To leave this section blank, add a word space to delete the instructions.

There are ethical and legal exceptions to confidentiality and include, but not limited to, the following:
1. When there is evidence of clear and present danger of harm to yourself and others
2. When there is knowledge of abuse or neglect of children or elderly persons
3. When court subpoenas records
4. When a client cites his or her clinical/treatment record in a legal proceeding
5. As otherwise mandated by a legal proceeding

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Instruction F: Insert Effective Date of Notice here.

This Notice of Privacy Practices applies to the following organizations.

Instruction G: If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

Instruction H: Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.

Disability Rights North Carolina

Champions for Equality and Justice: NC's Protection and Advocacy System

Do you know your rights?
Every person is entitled to equal protection under the law.
Disability Rights NC can help if you have questions about your rights.

Reach us toll free at: 877-235-4210

You have the right to:

- Treatment, including medical care & habilitation, regardless of age or degree of MH/IDD/SA disability
- Consent to or refuse treatment
- Be free from abuse and neglect
- Access to technology needed for communication, transportation, etc.
- Be free from discrimination in housing, transportation, employment or access to public/private programs and services
- Basic support, personal care, therapy, healthcare and other individualized treatment
- Special education

What does *Disability Rights North Carolina* do?

- Represent people based on targets & case selection criteria
- Educate people with disabilities about their legal, civil and service rights
- Investigate complaints about neglect, abuse and related deaths in institutions
- Provide advice, training and support for self-advocacy
- Reach out to traditionally underserved ethnic and disability communities
- Litigate to improve the lives of groups of people with disabilities.

We value the dignity of ALL people and their freedom to control their own lives. We work for justice upholding the fundamental rights of people with disabilities to live free from harm in the communities of their choice with the opportunity to participate fully and equally in society. If you have questions or would like information in Braille, on cassette tape, or CD, call us at:

877-235-4210 voice
888-268-5535 TTY
Fax: 919-856-2244

Se habla español
Disability Rights North Carolina
2626 Glenwood Avenue, Suite 550
Raleigh, North Carolina 27608

For grievances & complaints related to the Trillium Health Resources provider network, call 1-866-998-2597

If you still need further assistance related to grievances & complaints, call Department of Health & Human Services Customer Service at 1-855-262-1946 (Voice/Spanish) or email at [redacted]

Other Resources:

Dept. of Health Service Regulation
2701 Mail Service Center
Raleigh, NC 27699-2701
Complaint Intake Dept.: 919-855-4500

Dept. of Social Services
2401 Mail Service Center
Raleigh, NC 27699-2401
Main Number: 919-733-3055

HAVEN
20 South 16th Street, Wilmington, NC 28401
PHONE 910.399.3927 FAX 910.399.3928

20 South 16th Street, Wilmington, NC 28401

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Pledge

We want you to understand that we respect your privacy. Other than the necessary uses and disclosures we described below, we will not sell your health information or provide any of your health information to any outside marketing company.

Uses and Disclosures

Below you will find examples of how we may have to use or disclose your health care information:

1. Your doctor or a staff member may have to disclose your health information (up to and including all of your clinical records) to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

2. It may be necessary for our insurance and/or billing staff to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, your employer, a family member, other relative or close personal friend, who is involved in our care or to facilitate the payment related to your care.

3. It may be necessary for the doctor and members of the staff to use your health information, examination, and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.

4. Your doctor and members of the practice staff may need to use your information (ex. name, address, phone number, and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

As our patient, you possess the right to refuse to give us the authority to contact you regarding the above-mentioned circumstances. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing services to you based on the orders of another health care provider.

2. If we provide health care services to you in an emergency or disaster relief situation.

3. If we are required by law to treat you and we are unable to obtain your consent after attempting to do so.

4. If we are provide health care services to you as a result of a Workers' Compensation injury.

5. If you are/ were a member of the armed forces, we are required by military command authorities to release your health information.

6. If we provide health care services to you as an inmate.

7. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the above examples, any other use or disclosure of your health information will only be made with your written consent.

Your right to revoke your authorization

You may revoke (take away) your privacy release authorization from us at any time; however, your revocation must be in writing. You can call for information about revoking your authorization during normal business hours, or send your request to the address listed below. There are two circumstances under which we will not be able to honor you revocation request.

1. If we have already released your health information before we received your request to revoke your authorization. 164.508(b)(5)(i).

2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at:

HAVEN
7212 OYSTER LANE
WILMINGTON, NC 28411-7132

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care form another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and /or copy your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to inspect and / or copy your health information be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records
You have the right to request that we give you and accounting if the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- Those disclosures made to you.

- Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.
- Those disclosures made for national security or intelligence purposes.
- Those disclosures made to correctional officers or law enforcement officers.
- Those disclosures that were made prior to the effective date of the HIPPA privacy law.

(This section of the free HIPAA privacy release form is to inform your patients about your legal requirements to protect their health information, and that the patients rights may change as laws change etc. Did I mention that this is not a legal document, and should not be considered legal advice. Have you called an attorney yet?)

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change in our privacy terms the change will apply for all of our health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

For more information or to report a problem

If you have questions and would like additional information, you may contact our practice's Chief Privacy Officer at (910) 803-1620, or in writing to the Chief Privacy Officer, (7212 OYSTER LANE WILMINGTON, NC 28411-7132). If you believe your privacy rights have been violated, you can either file a complaint with this office, or with the office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for North Carolina is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3870
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I understand I may receive a paper copy with this authorization at my request. This notice is effective as of: (Date) _____. This authorization will expire seven years after the date in which you last received services form us.

ASSIGNMENT OF BENEFITS: I voluntarily direct NC MEDICAID / MEDICARE / OTHER: _____ to pay HAVEN directly for charges for professional services rendered to me. THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY. I agree that I am not responsible for any balance over and above insurance payments for these services.

CONSENT TO TREAT: I voluntarily authorize HAVEN and employees DWIGHT LYSNE, MD, MDIV (Board Certified Child & Adolescent Psychiatrist) to administer examinations and care as deemed necessary for my condition. I have the right to refuse treatment at any time. I have the right to withdraw consent at any time. I have the right to treatment, including access to medical care and habilitation regardless of age or degree of mental health, intellectual and developmental disabilities, and/or substance abuse disability.

Patient's Name Printed _____

Patient's Name Signed _____

Date _____

Parent / Legal Guardian Printed _____

Parent / Legal Guardian Name Signed _____

Date _____

AUTHORIZATION TO RELEASE RECORDS: I voluntarily authorize the release of any information pertinent to my case to any insurance company, (e.g. Medicaid) involved in my case.

Patient's Name Printed _____

Patient's Name Signed _____

Date _____

Parent / Legal Guardian Printed _____

Parent / Legal Guardian Name Signed _____

Date _____

Authorization for Lab Billing: I, the undersigned, understand and grant permission to Radeas Laboratory to bill my health insurance for services provided. I understand that I may be responsible for co-pays and deductibles not covered by my insurer. By signing I acknowledge that payment(s) may be made on my behalf to Radeas Laboratory. I hereby allow the release of any personal or medical information as needed to process this claim.

Patient's Name Printed _____

Patient's Name Signed _____

Date _____

Parent / Legal Guardian Printed _____

Parent / Legal Guardian Name Signed _____

Date _____

Patient Information:

Name:_____

Sex: _____ Date of Birth:_____ Social Security Number:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Insurance:_____

Ethnicity:

Hispanic or Latino:___ Not Hispanic or Latino:___ Patient decline to specify:___

Race: (Please check all that apply)

American Indian or Alaska Native:___ Asian:___ Black or African American:___

Native Hawaiian or other Pacific Islander:___ White:___ Patient declined to specify:___

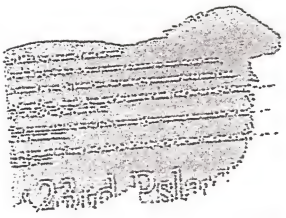
Preferred language:_____

Emergency Contact Name:_____

Phone Number:_____

Address:_____

Mother's Maiden Name:_____



Haven
20 S. 16th St. Wilmington, NC 28401
910-399-3927 Fax: 910-399-3928

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member:_____MR#:_____DOB:_____Medicaid#:_____

Use this form to obtain client or legally responsible person/persons representative authorization for the one-way authorization. Form must be completely filled out before client or legally responsible person/persons representative signs. File original in client record.
MUST GIVE COPY TO CLIENT
This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R parts 160. 164), the federal drug and alcohol confidentiality law (42 C.F.R part2). and state confidentiality law governing mental health. developmental disabilities. and substance abuse services (G.S 122C).

I, _____ authorize Haven to use or disclose to
(Client or client's legally responsible person or personal representative)

PRIMARY CARE : _____ Tel/Fax#_____
(Agency or person to whom the requested use or disclosure will be made)

The following protected information:

- ☒ Admission Assessment/Screening
- ☐ Social, Family, Medical, Developmental
- ☒ Substance Abuse, Legal, Histories
- ☒ Service Plan/PCP
- ☒ Discharge. Admission, Tx Summaries
- ☐ Probation/Legal hx/court info
- ☒ Case Management/psychotherapy Notes
- ☒ Psychological/Psychiatric Evals/Progress Notes
- ☐ School psych/Tests/Eval/Attendance/progress/ed. info
- ☐ HIV/AIDS Information
- ☒ Medication Hx/Psysician's Orders/Notes/prognosis/medical/medication lists
- ☐ Other (Specify)_____

The purpose of this disclosure is:

- ☐ Insurance/Medicaid/Medicare determination of Benefits
- ☒ To assist in the development of individual service/goals/plans
- ☐ To provide date to assist with evaluation/assessment/prescriptive services
- ☒ Coordination of Services between agencies
- ☐ Assist in securing benefits

Once information is disclosed pursuant to this authorization, I understand that the federal health privacy law (45 C.F.R Part 164) protecting health information may not apply to the recipient of this information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws. however. may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S.122C) or substance abuse treatment information protected by federal law (42 C.F.R Part 2). we must inform the recipient of this information and the disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permited or required by these laws. I understand that the information to be released may include information regarding psychological. psychiatric. or physical impairments.

REVOCATION AND EXPIRATION

I understand that, with certain exception. I have the right to revoke this authorization at any time. except to the extent that action has been take in reliance on it. The procedure for how I may revoke this authorization. as well as the exceptions to my right to revoke, are explained in Haven Notice of Privacy Practices, a copy has been provided to me. If not revoked earlier, this authorization expires automatically upon:

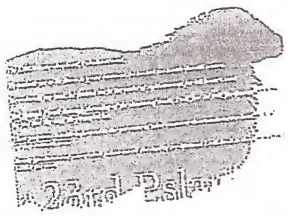
_____or one year from the date it is signed whichever is earlier.

NOTICE OF VOLUNTARINESS

I certify that this authorization is made freely. voluntarily. and without coercion. I understand that Haven cannot deny or refuse to provide treatment if I refuse to sign this authorization, except in limited circumstances. i.e. research related treatment, services provided solely for reason of creating PHI for disclosure to 3rd party.

SIGNATURE

Signature: _____ Date: _____
(specify if signature is that of client, legally responsible person or other personal representative)
Please explain representative's authority to act on behalf of client _____
Signature: _____ Date: _____
Minor signature required if substance abuse diagnosis_____



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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member:_____MR#:_____DOB:_____Medicaid#:_____

Use this form to obtain client or legally responsible person/persons representative authorization for the one-way authorization. Form must be completely filled out before client or legally responsible person/persons representative signs. File original in client record.
MUST GIVE COPY TO CLIENT
This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R part2), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S 122C).

I. _____ authorize Haven to use or disclose to
(Client or client's legally responsible person or personal representative)

PHARMACY: _____ Tel/Fax#_____
(Agency or person to whom the requested use or disclosure will be made)

The following protected information:

- ☐ Admission Assessment/Screening
- ☐ Social, Family, Medical, Developmental
- ☐ Substance Abuse, Legal, Histories
- ☐ Service Plan/PCP
- ☐ Discharge, Admission, Tx Summaries
- ☐ Probation/Legal hx/court info
- ☐ Case Management/psychotherapy Notes
- ☐ Psychological/Psychiatric Evals/Progress Notes
- ☐ School psych/Tests/Eval/Attendance/progress/ed. info
- ☐ HIV/AIDS Information
- ☒ Medication Hx/Psysician's Orders/Notes/prognosis/medical/medication lists
- ☐ Other (Specify)_____

The purpose of this disclosure is:

- ☐ Insurance/Medicaid/Medicare determination of Benefits
- ☒ To assist in the development of individual service/goals/plans
- ☐ To provide date to assist with evaluation/assessment/prescriptive services
- ☒ Coordination of Services between agencies
- ☐ Assist in securing benefits

Once information is disclosed pursuant to this authorization, I understand that the federal health privacy law (45 C.F.R Part 164) protecting health information may not apply to the recipient of this information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S.122C) or substance abuse treatment information protected by federal law (42 C.F.R Part 2), we must inform the recipient of this information and the disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws. I understand that the information to be released may include information regarding psychological, psychiatric, or physical impairments.

REVOCATION AND EXPIRATION

I understand that, with certain exception, I have the right to revoke this authorization at any time, except to the extent that action has been take in reliance on it. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in Haven Notice of Privacy Practices, a copy has been provided to me. If not revoked earlier, this authorization expires automatically upon:
_____or one year from the date it is signed whichever is earlier.

NOTICE OF VOLUNTARINESS

I certify that this authorization is made freely, voluntarily, and without coercion. I understand that Haven cannot deny or refuse to provide treatment if I refuse to sign this authorization, except in limited circumstances, i.e. research related treatment, services provided solely for reason of creating PHI for disclosure to 3rd party.

SIGNATURE

Signature: _____ Date: _____
(specify if signature is that of client, legally responsible person or other personal representative)
Please explain representative's authority to act on behalf of client _____
Signature: _____ Date: _____
Minor signature required if substance abuse diagnosis

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MUST GIVE COPY TO CLIENT
This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R parts 160, 164). the federal drug and alcohol confidentiality law (42 C.F.R part2). and state confidentiality law governing mental health. developmental disabilities. and substance abuse services (G.S 122C).

1. _____ authorize Haven to use or disclose to
(Client or client's legally responsible person or personal representative)

SUPPORT PARTNER: _____ Tel/Fax#_____
(Agency or person to whom the requested use or disclosure will be made)

The following protected information:

_____☐ Admission Assessment/Screening
_____☐ Social. Family. Medical. Developmental
_____☐ Substance Abuse. Legal. Histories
_____☐Service Plan/PCP
_____☐ Discharge. Admission. Tx Summaries
_____☐ Probation/Legal hx/court info
_____☐ Case Management/psychotherapy Notes
_____☐ Psychological/Psychiatric Evals/Progress Notes
_____☐ School psych/Tests/Eval/Attendance/progress/ed. info
_____☐HIV/AIDS Information
_____☐ Medication Hx/Psysician's Orders/Notes/prognosis/medical/medication lists
_____☒ Other (Specify) RE: RECOVERY

The purpose of this disclosure is:

_____ Insurance/Medicaid/Medicare determination of Benefits
_____ To assist in the development of individual service/goals/plans
_____ To provide date to assist with evaluation/assessment/prescriptive services
_____ Coordination of Services between agencies
_____ Assist in securing benefits

Once information is disclosed pursuant to this authorization, I understand that the federal health privacy law (45 C.F.R Part 164) protecting health information may not apply to the recipient of this information and, therefore. may not prohibit the recipient from re-disclosing it. Other laws. however. may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S.122C) or substance abuse treatment information protected by federal law (42 C.F.R Part 2). we must inform the recipient of this information and the disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws. I understand that the information to be released may include information regarding psychological. psychiatric. or physical impairments.

REVOCATION AND EXPIRATION

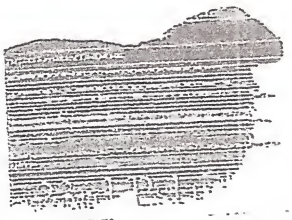
I understand that. with certain exception, I have the right to revoke this authorization at any time. except to the extent that action has been take in reliance on it. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke. are explained in Haven Notice of Privacy Practices. a copy has been provided to me. If not revoked earlier. this authorization expires automatically upon:
_____or one year from the date it is signed whichever is earlier.

NOTICE OF VOLUNTARINESS

I certify that this authorization is made freely. voluntarily. and without coercion. I understand that Haven cannot deny or refuse to provide treatment if I refuse to sign this authorization, except in limited circumstances. i.e. research related treatment. services provided solely for reason of creating PHI for disclosure to 3rd party.

SIGNATURE

Signature: _____ Date: _____
(specify if signature is that of client. legally responsible person or other personal representative)
Please explain representative's authority to act on behalf of client _____
Signature: _____ Date: _____
Minor signature required if substance abuse diagnosis_____



HAVEN MINISTRIES, INC.
20 16th Street South Wilmington, NC 28401 Phone 910-399-3927 Fax 910-399-3928

HAVEN MINISTRIES, INC. APPOINTMENT CONTRACT

Failed or appointments cancelled without 24 hours notice:

1. May indicate underlying therapy issues such as trust, avoidance, responsibility and commitment. A no-show policy provides a way to address and intervene in these personal issues when they are interfering with the treatment process.

2. Results in inadequate care because it interferes with the development of the therapeutic or working relationship and because it results in compliance problems with medication treatment.

3. May result in unnecessary and avoidable crises and safety concerns for clients, their support systems, and the professionals working with them.

4. Disrupts the operation of the clinic because it creates additional work for the office staff through time spent in unnecessarily preparing for appointments, through time spent in rescheduling appointments, through time spent in refilling medications that run out, and through lost revenue for these appointments.

You are being informed of Haven Ministries, Inc. no show policy in writing:

1. At the time of your intake when you sign other consents and releases of information.

2. Because you are making a commitment to accept help and receive care and service this clinic has to offer.

3. Because you will be allowed only 3 failed appointments and/or appointments canceled without 24 hours notice within a 12 month period of time.

4. Because if you exceed 3 of these appointments in a 12 month period of time you will not be able to receive services at Haven Ministries, Inc. for one year.

You will not be penalized for missing appointments for legitimate reasons or emergencies are arise which you have no control over.

Client Signature_____ Date_____

Witness Signature_____ Date_____

HAVEN MINISTRIES, INC.
20 16th Street South Wilmington, NC 28401 Phone 910-399-3927 Fax 910-399-3928

HAVEN MINISTRIES, INC. RECOVERY CONTRACT

Haven Ministries is a joint outreach recovery program of Haven Church & Clinic offering a recovery contract to those who voluntarily come seeking health and healing.

1. I will follow the central recovery rule: "No Matter What, Don't Drink, Don't Use Drugs, And Take Your Medications As Prescribed, No Matter What" acknowledging that if I sell, share, borrow, give away, abuse, or misuse my medication in any way it could result in my immediate dismissal from treatment.

2. I will provide a urine sample for a drug screen when asked following established protocol acknowledging that tampering with urine samples and refusing to provide an adequate sample could result in my immediate dismissal from treatment.

3. I will provide a breathlyzer examination when asked acknowledging that refusing to cooperate or refusal to do so could result in my immediate dismissal from treatment.

4. I will submit to screens for needle marks when asked acknowledging that refusal to do so could result in my immediate dismissal from treatment.

5. I will submit to at least weekly pill counts of all controlled substances I am being prescribed acknowledging that any deception on my part by not bringing all the pills I have obtained from the pharmacy, not acknowledging all the controlled substances I am being prescribed, falsifying my count by borrowing pills, falsifying my count by using look-a-like pills, or any other form of deception could result in my immediate dismissal from treatment.

6. I will keep my medications safe in a locked box at all times and bring my controlled substances to all pill counts in my lock box.

7. I will work with my designated support partner in taking my medication daily under supervision and will sign a release of information between my support partner and Haven Ministries to facilitate communication about my compliance with the medication(s) being prescribed to me.

8. I will obtain my medications from one pharmacy and will sign a release of information between my pharmacy and Haven Ministries to facilitate communication about the frequency of my filling prescriptions, addressing any concerns the pharmacy may have, and I will be responsible for obtaining a pharmacy printout of all refills I have obtained each week on Saturday so it is available for the weekly pill count in order to accurately reconcile my pill count. If I change pharmacies it is my responsibility to notify Haven Ministries of the change.

9. I will not obtain controlled substances from any other provider while I am in recovery at Haven Ministries (benzodiazepines, sleeping medications, ADHD medications, pain medications) acknowledging that this could result on my immediate dismissal from treatment.

9. I acknowledge that I will be monitored on the NC Controlled Substances Website at least monthly while I am in recovery at Haven Ministries.

10. I will not borrow or buy any controlled substance (benzodiazepines, sleeping medications, ADHD medications, pain medications) from a friend, acquaintance or family member while in recovery at Haven Ministries and acknowledge that if I do this could result in my immediate dismissal from treatment.

11. I will be responsible for attending my recovery meetings, my relapse prevention group, and my medication reviews as well as any specialty groups that are recommended for me acknowledging that noncompliance could result in my immediate dismissal from treatment.

12. I will be responsible for payment of my clinic charges at the time of my appointment acknowledging that failure to do so or failure to make arrangements for payment of my bill could result in my not being seen at the clinic.

13. I acknowledge that Haven Ministries is a Christian Recovery Program with a foundation in the Gospel of Jesus Christ. As such Haven Church provides Daily Supervised Administration of Medication 8:00 am & 6:15 pm, Daily Support Groups 8:30 am & 5:45 am, a 12 Step Group (Celebrate Recovery) Sundays at 10:00 am, Worship Sundays 9:00 am & 11:00 am, and Pill Counts Sundays 10:00 am. Haven Clinic provides mental health & substance abuse assessment, medication management & review, and individual & group therapies.

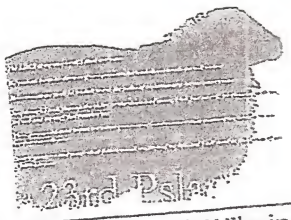
14. I will commit to the process of recovery which involves a basic change or transformation in who I am, a basic change from my denial that I am able to manage my life on my own terms that I have the power to change myself, to stop believing the lies I have been telling myself that has been causing me a lot of pain and suffering that I have been self-medicating with alcohol or drugs so I can begin to discover the truth about myself.

15. I will commit to engaging in recovery so I don't continue to isolate myself and remain alone and lonely and in the dark and instead will take risks in order to begin relating to other people in healthy ways by accepting forgiveness, forgiving myself, and forgiving others so the walls I have built up over the years can come down and I can begin participating in true fellowship with other people, supporting and helping others when they need it and allowing others to support and help me when I need it.

16. If I prematurely leave recovery at Haven Ministries I acknowledge that I can reenter after a period of 3 months.

Client Signature_____ Date_____

Witness Signature_____ Date_____



HAVEN MINISTRIES, INC.
20 16th Street South Wilmington, NC 28401 Phone 910-399-3927 Fax 910-399-3928

BUPRENORPHINE TREATMENT AGREEMENT

I am requesting that my doctor provide buprenorphine treatment for opioid _____ addiction. I freely and voluntarily agree to accept this treatment agreement, as follows:

1. I agree to keep, and be on time to, all my scheduled appointments with the doctor and his/her assistants.

2. I agree to conduct myself in a courteous manner in the physician's or clinic's office.

3. I agree to pay all office fees for this treatment at the time of my visits. I will be given a receipt that I can use to get reimbursement from my insurance company if this treatment is a covered service. I understand that this medication will cost between $5-$10 a day just for medication and that the visit are a separate charge.

4. I agree not to arrive at the office intoxicated or under the influence of drugs. if I do, the staff will not see me and I will not be given any medication until my next scheduled appointment.

5. I agree not to sell, share or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.

6. I understand that the use of buprenorphine/naloxone (Suboxone) by someone who is addicted to opioids could cause them to experience severe withdrawal.

7. I agree not to deal, steal, or conduct any other illegal or disruptive activities in or in the vicinity of the doctor's office.

8. I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.

9. I agree that the medication I receive is my responsibility and I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.

10. I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines, such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and or drugs including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines.

11. I agree to take my medication as the doctor, and his/her assistant has instructed, and not to alter the way I take my medication without first consulting the doctor.

-OVER-

12. I understand that medication alone is not sufficient treatment for my disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my treatment.

13. I understand my buprenorphine treatment may be discontinued and I may be discharged from the clinic if I violate this agreement.

14. I understand that there are alternatives to buprenorphine treatment for opioid addiction including:

a) medical withdrawal and drug-free treatment

b) naltrexone (Vivitrol) treatment

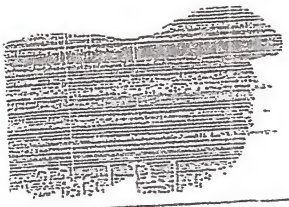
c) methadone treatment

My doctor will discuss these with me and provide a referral if I request this.

Client Signature_____ Date_____

Witness Signature_____ Date_____

MD Prescriber_____ Date_____



HAVEN MINISTRIES, INC.
20 16th Street South Wilmington, NC 28401 Phone 910-399-3927 Fax 910-399-3928

PATIENT CONSENT AND RELEASE FORM FOR
BUPRENORPHINE TREATMENT DURING PREGNANCY

I, _____, am currently receiving prenatal care from _____. Because I am currently prescribed buprenorphine combined with naloxone (Suboxone) for treatment of my opioid addiction and do not wish to take methadone, my doctor has referred me to the opioid-based outpatient treatment program for treatment with buprenorphine for treatment of my opioid addiction during my pregnancy. During my pregnancy, I agree to be switched from the combination tablet of buprenorphine with naloxone (Suboxone) to the non-combination buprenorphine tablet (Subutex) as recommended by national addiction treatment guidelines. _____ will provide my pre-natal care.

I have met with _____ at the opioid-based outpatient treatment program and s/he has discussed with me and I understand the risks and benefits of taking buprenorphine and those associated with taking methadone during pregnancy.

I have been informed that the federal Food and Drug Administration (FDA) has not approved the use of buprenorphine for the treatment of opioid addiction in pregnant women. Whereas, methadone has been FDA approved for the treatment of opioid addiction during pregnancy and there is over 40 years of experience showing methadone treatment to be safe and effective during pregnancy. Therefore, it is currently believed that methadone is safer than buprenorphine for the treatment of opioid addiction during pregnancy.

Although small research studies have been completed in Europe and research is now being conducted in the United States on the effects of buprenorphine on pregnant women and their unborn children, currently there is too little information available to say that buprenorphine is safe during pregnancy.

There have been studies of the effects of buprenorphine on laboratory animals. Buprenophine has caused some bone problems in laboratory animal embryos and fetuses after injections of buprenorphine but not when the same amount of buprenorphine was given by mouth.

A possible problem of taking any opioid (heroin, methadone, or buprenorphine) during pregnancy is that after birth the child may suffer a withdrawal syndrome called Neonatal Abstinence Syndrome. Babies with Neonatal Abstinence Syndrome may suffer from sleep disturbances, feeding difficulties, tremor, sneezing, irritability, vomiting, weight loss, and seizures. A large proportion of these children will require hospitalization, often for long periods of time.

I understand these risks and benefits and have decided to take buprenorphine (Subutex) rather than methadone. I understand that medical knowledge on the actual or potential risks of buprenorphine on pregnant women and unborn children is not at all certain. I accept responsibility for this decision.

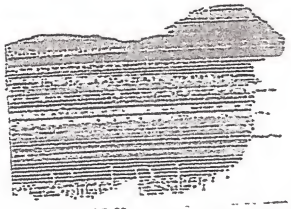
-OVER-

On behalf of myself and my unborn child, I hereby release and agree to hold harmless, the program, the prescribing doctor, and hospital's officers, directors, agents and employees from any liability of any kind which may arise in connection with my taking buprenorphine (Subutex) during the duration of my pregnancy.

Client Signature_____ Date_____

Witness Signature_____ Date_____

MD Prescriber_____ Date_____



HAVEN MINISTRIES, INC.
20 16th Street South Wilmington, NC 28401 Phone 910-399-3927 Fax 910-399-3928

HAVEN MINISTRIES, INC. MASTER CONSENT SUMMARY

___ I have read, understood & signed HIPPA relating to keeping my medical information confidential.

___ I have read, understood, & signed the appropriate releases of information to facilitate my care.

___ I have read, understood, signed & will abide by Haven Ministries Office Policies.

___ I have read, understood & signed Haven Ministries Recovery Contract.

___ I have read, understood, signed & will abide by the Buprenorphine Contract.

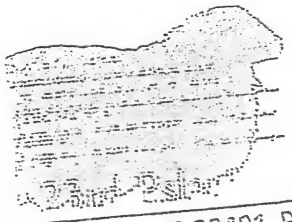
___ I have read, understood, signed & will abide by the Pregnancy Buprenorpine Contract.

___ I have received a copy of Client's Rights.

___ I have received a copy of the Grievance Procedure.

Client Signature_____ Date_____

Witness Signature_____ Date_____



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20 16th Street South Wilmington, NC 28401 Phone 910-399-3927 Fax 910-399-3928

HAVEN BEACON 3/2/2014

I am writing to communicate two updates to the Haven congregation.

Unpaid Bill Policy

As previously informed, all unpaid bills are due now. This includes unpaid balances for clinical appointments and therapy groups as well as for the cost of supervised medication administration and weekly pill counts provided by the Church.

Anyone with an unpaid bill will not be offered services through the Haven Clinic until their balance is paid in full. This includes the service of writing for medication refills.

Also, payment for service is now due in full at the time of your appointment. Service will not be provided if payment is not received at the time of your scheduled appointment.

There are several reasons for this including the need for those in recovery to take personal responsibility for their care and the need for the clinic to have adequate cash flow to operate effectively in order to continue providing clinical service to those who seek care here.

As it now stands Haven is barely making it even though it is operating with a minimal level of staffing that cannot continue indefinitely into the future without burning out those who are working here. Several support staff are needed to reduce the work load that is currently being carried by a few including full time positions for nursing, a chemical dependency counselor, an associate pastor, as well as reception and secretarial services to name a few.

Haven becomes part of the recovery problems that exist in our midst when it doesn't have sufficient accountability regarding payment for the services it provides—especially when urine drug screens are positive for drugs of abuse, indicating money is being spent to continue in addiction instead of going to support the recovery process.

Recovery Policy

Recently the policy regarding the first 90 days of recovery was updated to address the need for increased accountability in order to improve the rate of recovery.

The updated policy includes the allowance of one unexcused absence per month in attending the daily supervised administration of medication and one unexcused absence per month in attending the daily devotional support groups.

During the first 90 days dosing under supervision daily is done to help break all the bad habits that exist in management of medication including issues such as taking more medication than prescribed, taking prescribed medication in the wrong way, and the selling or sharing of medication.

Supervised medication administration has the goal of helping to gain respect for the sacredness of medication in the healing process as a gift from God. Misuse of prescribed medication undermines both the therapeutic alliance necessary for recovery and turns God's gift into a negotiable commodity.

Daily devotional groups provide training in developing a foundation for living each day prepared for anything—especially the unexpected things that life can bring. It anchors our lives on the LORD who provides us with the strength, wisdom and guidance we need in order to constructively cope with the things we are vulnerable to.

Recovery involves making a radical change and without having accountability radical change is not likely to occur. Supervised dosing and daily devotional support groups for a period of 90 days help to get our focus off ourselves and on Jesus Christ in order to facilitate the radical change necessary to become Liberated from addictions.

Recovery takes time and a lot of effort. It is a full time job and if not approached in this way radical change doesn't occur. Having a full time job involves taking on several responsibilities including showing up for work, showing up on time, and managing the resources entrusted to you.

The standard that operates in the workforce is that if you show up late or not at all you will be let go and replaced by someone who will. The standard in the workforce is that if you do not wisely manage the resources entrusted to you, e.g. handling money, handling inventory, you will be let go and replaced by someone who will.

This is why in recovery if you don't take responsibility for showing up for what you are suppose to, if you show up late for what you are suppose to, if you fail to take financial responsibility for the service provided you, or if you mismanage the medication entrusted to you—it signals that you are not ready for recovery and need to be replaced by someone who is.

With the limited openings that exist for recovery, Haven needs to be wisely investing its limited time, energy and resources in the lives of those who are ready to recover instead of exhausting itself on those who are not ready to take responsibility for their lives. This includes those who repeatedly increase the work load by taking the limited time, energy and resources due to noncompliance. They do so by having to be tracked down for not coming when they are suppose to, for coming late to what they are suppose to, for failing to take financial responsibility for the services they receive, for failing to manage their medications properly, for failing to invest themselves in new ways of coping by continued use of substances instead of reaching out to others for help in trying something new. This includes not only some who are in their first 90 days of recovery at Haven but others who have been in recovery at Haven for some time.

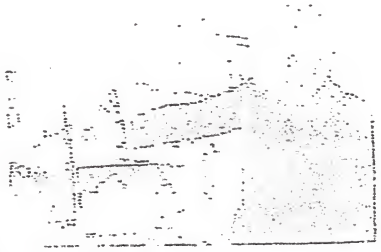
Because of this there are some who are currently at Haven who have given clear repeated signals they are just not ready to be here. They will need to try something new instead of Haven engaging in exhaustive attempts to make them responsible for their recovery. They need to step out of recovery at Haven for a period of 90 days or enter a more intense recovery setting for a period of time before returning to Haven.

In Christ,

Dwight Lysne, MD, MDiv
Haven Pastor & Medical Director

Doctor finds peace helping others at Haven Ministries

By Si Communi
Published: Friday, February 21, 2014 at 10:27 a.m.



Jason A. Frizzelle
Dr. Dwight Lysne with Haven Ministries sorts medications at the ministry.

Before Kristy Shelton found Haven Ministries, she had lost everything.

Shelton, now 41, started out as a Fayetteville hair stylist, married and raising raising two children. Then came the drugs.

"My husband was an addict," she said. "He was using a lot. ... I started using to block him out."

She became an addict herself, spending a decade using cocaine and pills. She lost her business and her family, and spent time in jail.

Before he came to Haven, Luke Duggan was hooked on OxyContin, a powerful medication originally prescribed for him after a bad accident.

Now both are discipleship leaders at Haven Ministries, a Christian-based program that provides mental health and substance abuse care to people who need it, regardless of ability to pay.

It's housed in an office at 20 S. 16th St. leased from St. Andrews-Covenant Presbyterian Church.

The ministry and psychiatric clinic was founded by Dr. Dwight Lysne. Like his clients, he lost much in the journey that took him from teaching and practicing psychiatry in North Dakota to his present post.

The Fargo, N.D., native spent 10 years as a prosperous doctor and child psychiatry professor before asking, "Is this all there is?"

"This isn't the fulfilling life I thought I would have," he recalls thinking.

He began attending a Bible study group and realized it was the only time where he felt peace.

"My perspective changed. Making money had become an empty pursuit," he said.

"That's when things started to change for me," he said. "I found myself led to seminary."

He moved his family to Winston-Salem in 2003 to accommodate a teenage daughter who wanted to dance at the N.C. School of the Arts.

He later served as medical director of Wilmington's Yahweh Center, which provides psychiatric services to children traumatized by violence or abandonment.

Haven started as a part-time commitment while he was working elsewhere. But around the beginning of 2011, he devoted himself full-time to the storefront ministry, which is both a church and a psychiatric clinic.

It hasn't been easy.

'God was peeling back my possessions, my money, my title," he said. Lysne even went unemployed for a time.

Relations with friends and some extended family members became strained.

"All that was preparing me to have empathy for people struggling," he said.

St. Andrews-Covenant Presbyterian Church provides some financial assistance to Haven, and church members volunteer with the ministry.

Sixty to 70 percent of Haven's clients have no insurance.

Lysne specializes in treating patients with mental health issues. Many are addicted to opioids, drugs derived from natural or synthetic opium substances. They include prescription medicines and street drugs.

He prescribes medication to ease their withdrawal symptoms. He leads church services, Bible studies and support groups to nurture their spiritual lives.

Not all its members use the clinical services.

"My mission is to grow as a church," he said.

The day I visited, the chapel was being decorated for the wedding of a Haven client.

Lysne hopes the leadership group he has established for clients who become able to help others will ensure that Haven goes on.

"When I retire or die, this place can continue to provide mental health and substance abuse care integrated with the Gospel," he said.

Haven would like to hear from "felony-friendly" businesses willing to give people a chance to change their lives. It also posts a list of its unpaid bills.

To help or learn more, call 399-3927 or visit www.havenministriesinc.org.

Column idea? Contact Si Cantwell at 343-2364 or Si.Cantwell@StarNewsOnline.com, or follow him on Twitter.com: @SiCantwell.

Self-Pay Clinic & Church Related Recovery Charges*

Year 1 Costs

Month 1 $300

Month 2 $300

Month 3 $300

Month 4 $200

Month 5 $200

Month 6 $200

Month 7 $150

Month 8 $150

Month 9 $150

Month 10 $150

Month 11 $150

Month 12 $150

Year One Total = $2400
($200 average per month)

Year 2 Costs

$150 per month

Yearly Total = $1800

*All inclusive costs per month - does not include cost of CR ($22.50) and Relapse Prevention ($14.80) Books

Medicaid Church Related Recovery Charges**

Year 1 Costs

Month 1 $80

Month 2 $80

Month 3 $80

Month 4 $60

Month 5 $60

Month 6 $60

Month 7 $40

Month 8 $40

Month 9 $40

Month 10 $40

Month 11 $40

Month 12 $40

Year One Total = $660
($55 average per month)

Year 2 Costs

$40 per month

Yearly Total = $480

**Non-Medicaid recovery costs for services provided by the church (supervised dosing, pill counts, weekly progress reports) – does not include cost of CR ($22.50) & Relapse Prevention ($14.80) Books

Medicare Church Related & Clinic Recovery Charges***

Year 1 Costs

Month 1 $80 + $60 = $140

Month 2 $80 + $60 = $140

Month 3 $80 + $60 = $140

Month 4 $60

Month 5 $60

Month 6 $60

Month 7 $40

Month 8 $40

Month 9 $40

Month 10 $40

Month 11 $40

Month 12 $40

Year One Total = $840
($70 average per month)

Year 2 Costs

$40 per month

Yearly Total = $480

***Non-Medicare recovery costs for services provided by the church (supervised dosing, pill counts, weekly progress reports) + Non-Medicare covered relapse prevention group ($60 monthly) – does not include cost of CR ($22.50) & Relapse Prevention ($14.80) Books

HAVEN
20 16th Street South Wilmington, NC 28401 Phone 910-399-3927 Fax 910-399-3928

CONTACT INFORMATION

The HAVEN Recovery Coordinator is Chad Suggs. He is available to answer any questions you have about the program at Haven. His phone number is:

910-899-6056

The HAVEN Clinic Nurse is Leslie Brown LPN. You may text your prescription refill refill requests to Leslie or you may fill out a Prescription Request Refill form and turn that it. You are not required to do both. Her text number is:

910-899-6055

The HAVEN Physician is Dwight Lysne MD. He can be contacted in an emergency by text message at:

910-465-1935

The Haven Office Manager is Bernt Lysne. He can be contacted with billing and scheduling questions at:

910-465-1936

We are all here to help you. It is our sincere desire for you to succeed in your recovery efforts here at HAVEN. All of our efforts and decisions are made with your best interests taken into consideration.